

**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT  
BUREAU OF CONSUMER HEALTH  
CHILD CARE LICENSING AND REGISTRATION SECTION  
1000 SW JACKSON, TOPEKA, KS 66612-1274\* SUITE 200  
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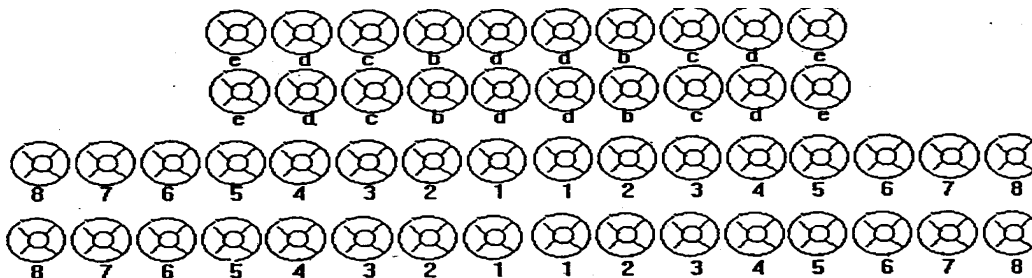


**CONTINUOUS DENTAL RECORD FOR CHILDREN IN FOSTER CARE**

Name of Child \_\_\_\_\_

Age \_\_\_\_\_

Name of Home or Facility \_\_\_\_\_



**LEGEND**

<b>Filling Present</b>	Fill in with <u>black</u>	<b>Missing Teeth</b>	Indicate with large black M
<b>Cavities</b>	Outline surfaces involved in <u>red</u> Draw parenthesis around when filled - ( )	<b>Teeth Indicated for Extraction</b>	Indicate with large red X
<b>Gum Inflammation</b>	Indicate in <u>red</u> beneath teeth involved	<b>Teeth Extracted</b>	Indicated with large black X

EXAMINATION	
<b>Deciduous teeth:</b> Decayed?      Stained? Calculous? Describe:	<b>Permanent teeth:</b> Decayed?      Stained? Calculous? Describe:
<b>Gums</b> Inflammation? Describe:	<b>Mucous membranes</b> Describe:
<b>Other oral manifestations</b> Describe:	
Do irremediable defects of the teeth exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is adequate fluoride present in the water supply? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is malocclusion present? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have fluoride applications been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No

**RECOMMENDATIONS**

- ☐ X-Rays      ☐ Restorations      ☐ Extractions      ☐ Other  
☐ Dental Prophylaxis      ☐ Fluoride Applications      ☐ Orthodontic Service

Continuous record of all services rendered on other side. \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## CONTINUOUS TREATMENT RECORD

Each entry must be identified by signature of dentist or dental hygienist.

[illegible]